



FSA/HRA REIMBURSEMENT REQUEST FORM

STEP 1 – Participant Information – Missing information may delay the processing of your reimbursement.

Name	Employer
Member ID #	Employee ID #
Street Address	Check if New Address <input type="checkbox"/>
City, State ZIP	Email Address

STEP 2 – Reimbursement Information

Current Plan Year
 Previous Plan Year

If a plan year is not indicated the claim will be filed for remaining dollars in the previous plan year if the plan has a grace period

Plan Type*	Date (s) Expense Incurred or range of dates	Product/Service Provider <small>Feel free to add all expenses for a Plan Type together as one claim</small>	Person Receiving Product/Service	Claim Amount	<input type="checkbox"/> Dependent Care Receipt attached OR Dependent Care Provider signature and Tax ID Number below

*Plan Types:

FSA – Health and Dependent Care Account
 HRA – Health Reimbursement Arrangement

Total Reimbursement Requested

Please attach copies of: an itemized bill showing service dates; and/or explanation of benefits from claim administrator, and/or statement from dependent care provider (including social security number of dependent care provider), and/or other proof of claim.

STEP 3 – Participant Certification

To the best of my knowledge and belief, my statements in this form are complete and true. I certify that the reimbursement requests I'm submitting are IRS eligible expenses and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from Insurance or any other source. I also understand the P5 Health Plan Solutions, it's agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I authorize a deduction in my account in the amount of the reimbursement. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid expenses under the Plan.

Participant Signature	Date
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For office use only: Plan Year 1 _____ Plan Year 2 _____
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FSA/HRA REIMBURSEMENT REQUEST FORM

Form Completion Guide

STEP 1: Participant Information

- Please write legibly. Missing information may delay the processing of your claim

STEP 2: Reimbursement Information

- Choose the plan year and indicate if you filed the claim online
- Plan Type Code:** Use the three-letter code below the grid to identify the account you desire reimbursement
- Date Expense Occurred or Provided:** Provide a date or a range of dates
- Product or Service Provider:** Give a short description of the service (ex. Dental, Rx, Dr. Jones, etc.)
- Person Receiving Product/Service:** Indicate what family member is receiving this service
- Claim Amount:** Provide the total requested amount from the documentation: Review your Summary Plan Description, Employee Guide, and read the guidelines and certification sections on this form.
- RECEIPTS: Please attach copies of:** an itemized bill showing service dates; and/or explanation of benefits from claim administrator, and/or statement from dependent care provider (including social security number of dependent care provider), and/or other proof of claim.
- Total Reimbursement Requested:** Total your claims.

STEP 3: Participant Certification

Sign and date the form after reading the Participant Certification. Your signature is required for reimbursement.

Documentation/Substantiation Guidelines

For medical reimbursements, please attach a copy of your insurance company's Explanation of Benefits (may be required for HRA accounts) or copies of receipts/bills if there is no insurance coverage to document the amounts. For Medical Spending Accounts, documentation should include the date and type of service, name of service provider, and the final responsibility for service. For additional information, please see the Summary Plan Description or call us toll-free at 1-800-922-1855.

Form Submission Guide

STEP 1: Gather supporting documentation/substantiation

STEP 2: Submit your claim to:

P5 Health Plan Solutions
 PO Box 9554, Salt Lake City, UT 84109-1217
 Email: tbarker@p5health.com
 Fax: 801-412-8542

STEP 3: Submit both the Reimbursement Request Form and a **copy** of your substantiation

P5 Health Plan Solutions will process your claim promptly (two business days from receipt). If there are any concerns about your claim, you will be notified in writing.

STEP 4: Track your submission below

Plan Type:

Date(s) of service submitted:

Type of service submitted:

Method submitted:

Date submitted:

Reimbursement received:
